

NQM Draft Requirements List Questions and Answers

Question 39: Concerning Section C-2 of the draft requirements list: It is recommend that a Memorandum of Understanding (MOU) be required among all parties within the TRICARE community to permit the sharing of data and information.

TMA defined the second objective of the contract as “The Contractor shall evaluate “best value health care” consistent with TRICARE requirements.” As identified in response to Question 12 in the Q&As already posted, “best value health care” is defined by the TRICARE Operations Manual as “[t]he delivery of high quality clinical and other related services in the most economical manner for the MHS that optimizes the direct care system while delivering the highest level of customer service.”

Given this definition and the TRICARE requirements, it is recommended to the TMA that a MOU be required among all parties to permit the sharing of data to identify topics, best practices, and best value/superior care – pursuing the balance between cost, quality, and access. Ideally, each and all parties involved in the delivery of health care to TRICARE beneficiaries (MCSC, NQMC, TDEFIC, DP, MTF, NQMP, Regional Offices, Lead Agent, and other quality focused groups) should have in place a signed MOU describing the establishment of a collaborative relationship designed to facilitate a continuous improvement in health care services. The purpose of that relationship would be to share data, other information, and opportunities to proactively improve health care, identify and apply superior care, and use and apply best-value health care.

At a minimum, the MCSCs and DPs should have in place a MOU with the NQMC to facilitate sharing of data and other information across the network portion of TRICARE. However, the more pieces of the TRICARE community that can be a part of a sharing community, the greater the results in improved care to TRICARE recipients. The fundamental practice of sharing data and information to improve care is being practiced in both the private and public sectors, as evidenced by the Institute for Healthcare Improvement’s Communities of Practice, the Leapfrog group, and the Pittsburgh Regional Healthcare Initiative, to name a few examples.

Response 39: Chapter 3, Section 1.0 of the TRICARE Operations Manual (TOM) states that the NQMC conducts reviews to validate the appropriateness of the contractor’s quality of care and utilization review decisions. The MCS contractor shall transmit copies of the medical record and all case documentation to the NQMC for each case or category of case requested by the NQMC. Section 1.1 of the TOM directs that the MCS contractor shall transmit complete records to the NQMC within 45 calendar days from the date the MCS contractor receives the request for records from the NQMC. Records to be transmitted shall include the complete medical record, the MCS contractor’s utilization review decision, rationale for that decision, and quality of care determinations. The MCS contractor shall incur all costs for obtaining and transmitting the records.

An MOU should not be necessary to accomplish the goals of the NQMC; however, TMA will review this suggestion again when the operational phase of the contract is underway.

Question 40: Concerning Section C-2 of the draft requirements list: The commenter recommends an addition to the final RFP language that calls for the TMA community of care providers (MTFs and contractors) to work together to successfully improve care delivered.

In order to maximize the benefits to TMA of objectives #2, #3, and #4 from the NQMC draft requirements, a collaborative relationship among and between the community of care providers, including the quality oversight contractors, is needed. It is recommended that TMA consider the following language to be added specifically to the MCSC, TDEFIC and NQMC procurements, as well as, to the requirements of the MTFs and DPs. In addition, TMA may also wish to consider adding the Mail Order and Retail Pharmacy contractors to this group.

Recommended language addition: The vision of the Military Health System (MHS) is to create a world-class health system. Given this goal and building on the successes across the health care industry, TMA wishes to create a quality improvement community of practice among the following organizations – MCSC, NQMC, TDEFIC, DP, MTF, NQMP, Regional Offices, Lead Agent, and other quality focused groups. Specifically, a collaborative relationship among and between such parties is needed to:

- a) Learn what internal quality improvement efforts are being done by the three MCSCs, the seven DPs, and MTFs to develop common topics, efforts, and eliminate duplication of effort,
- b) Openly share and discuss efforts and other information (via video- or teleconferences) to improve the focus and commitment that will achieve best practice-/best value-health care, specifically sharing what works and what does not work will help everyone to learn together,
- c) Maximize all quality improvement activities through TMA cooperation, including providing access to the NQMC to the MCSC data warehouse of valuable TRICARE healthcare information to identify areas of needed improvement and areas of where exceptional medical care is already provided,
- d) Ensure that efforts by NQMC to meet desired objectives (#2-#4) will be done in complement with the efforts of other TMA and DoD contractors to maximize return on investment in data collection and other activities.

Upon direction from the TMA, the NQMC contractor shall participate in the quality improvement community of practice. At a minimum, one community of practice will be established each contract year. Identification of the topic for the first community of practice will be determined after contract award. Examples of potential topics include patient safety issues, clinical topics, pharmacy, surgical infection or other efforts taken from the commercial sector. The Contractor shall provide data collection and analysis support to the community as directed by the TMA. In addition, other resources may also be required. **[End of new language].**

To achieve the maximum benefits to TRICARE recipients, all parties must know up front that a collaborative working relationship will be developed. This means all affected contracts should contain language and direction for allocating resources for quality monitoring, measurement, and improvement efforts. Because it is difficult at this point in time to pin point what this effort might encompass, one potential alternative is to identify this effort as a task order, and allocate a

cost reimbursement based budgeted dollar amount by year (not specific CLINS, given the variable amount of effort and resource per topic). For example, there is an allocation for disease management work currently in the MCSC procurement that could prove to be an excellent starting point for this effort.

Response 40: The role of the NQMC is to be independent and objective; TMA is not seeking a contractor that is part of the “community of practice”, but is desirous of a contractor that is external to that community. TMA does not intend to modify the language of any of the procurements cited by the commenter, but may review the recommendation after award of the MCSC, NQMC, TDEFIC, DP, MTF, and/or NQMP contracts.

Question 41: Section C-7.1.1 of the draft requirements list states that “The Contractor shall have available to it...the services of a sufficient number of actively practicing, Board-certified, licensed doctors of medicine or osteopathy actively practicing medicine or surgery to assure adequate peer review....”

Please consider modifying the requirement to state “The Contractor shall have available to it...the services of a sufficient number of actively practicing, Board-certified, licensed doctors of medicine or osteopathy actively practicing medicine or surgery, dispersed throughout the United States and its territories to assure adequate peer review.” Adding the requirement of a broader geographic distribution of physicians will ensure that TMA is provided with a truer peer review process, given the scope and diversity of TRICARE medical services.

Response 41: The requirement is for the NQMC to have available to it an appropriate number of staff with the appropriate qualifications; the geographical location of the staff is not a requirement that TMA will impose.

Question 42: Section C-7.4.1 of the draft requirements list states that “The contractor shall review medical, surgical, and mental health cases using recognized accepted utilization review criteria to provide consistent and standardized reviews....”

Please reconsider the emphasis of the review here: To fulfill TMA’s goals, the role of the NQMC should not be to validate which criteria are used, but to render a determination on the medical necessity of the patient to receive treatment. Alternative language to consider would be “The contractor shall review medical, surgical, and mental health cases to determine the medical necessity of the services provided. To carry out this review, the Contractor shall use industry recognized and accepted utilization review criteria to provide consistent and standardized reviews....”

Because the MCSC RFP does not specify criteria, it is likely that MCSCs will propose several different types of criteria for use at first-level review. Since criteria is used as a medical necessity screening tool at this review level, those cases failing criteria require referral to Board-certified, specialty-matched physicians to validate concerns based on patients symptoms and conditions at the time of treatment. Therefore, the differences in the criteria used by the MCSCs/DPs at first-level review should not be a significant concern.

Response 42: The intent of Section C-7.4.1 was for the NQMC to review cases using recognized, accepted criteria, such that the NQMC reviews were consistent and standardized; the intention was not to validate the criteria used by the MCSCs. The Government believed that the draft requirement was clear on this, but because this question was raised, the Government will clarify the language. It is anticipated that the comparable section in the RFP (expected to be released in early Spring 2003) will state that “The Contractor shall review medical, surgical, and mental health cases to determine the medical necessity and appropriateness of care of the services provided. To carry out this review, the Contractor shall use InterQual and American Society of Addiction Medicine (ASAM) criteria to provide consistent and standardized reviews in accordance with the documents specified in Section C-3 above.”

Question 43: Section C-7.5.1 requires the MCSC/DPs to respond within 45 days to the findings on the monthly report. Later, C-7.5.2.1 requires, “The contractor shall submit a six-month report beginning with Option Period 1, to be delivered 60 days (*underline added*) after the end of the six-month report period.”

Would TMA consider changing the requirement to 90 days to complete the report after the end of the six-month report period? The 90-day deadline is the current NQMC requirement. Additionally, to truly validate the responsiveness and timeliness of the MCSCs/DPs in responding to the findings on the monthly report within 45 days, the NQMC is then given 30 days once the comments are received to produce a final determination. The 60-day requirement on the six-month report means that the report could potentially be incomplete for the reporting period. If the MCSC/DP takes the full 45 days to respond, and the NQMC contractor takes the full 30 days to make a final determination, the determination will be completed in 75 days, 15 days past the due date for the six-month report. By changing the due date for the six-month report to 90 days, a comprehensive report can be produced.

Response 43: TMA anticipates that this requirement will be changed from 60 days to 90 days when the RFP is released in early Spring 2003.

Question 44: In Section C-7.6 the draft requirements state “As directed by TMA, the Contractor shall conduct focused studies....” Will focused studies be priced as a separate CLIN?

Like the community of practice initiatives described in Question 40 of this list of questions and comments, it is difficult to identify what level of effort a focused study might encompass. It might deal with a simple issue, like one-day stays, or a more complex issue like utilization patterns of cardiac catheterizations procedures. One potential alternative is to identify this effort as a task order, and allocate a cost reimbursement based budgeted total dollar amount by year (not specific CLINs, given the variable amount of effort and resource per topic).

Response 44: (Response modified 2/19/03)

It is anticipated that the RFP, when released in spring 2003, will indicate that the cost to perform focused studies will be negotiated on a per-study basis, and that the associated report’s delivery date will be negotiated as well. This requirement will likely include case reviews, and possibly some literature searches, for situations that have arisen concerning a specific provider.

As noted in Response 30, a sample of the focused studies report will be provided when the RFP is released.

Question 45: In section C-7.6, the draft requirements state “The contractor shall provide a summary report to TMA within 90 days.” Is the 90-day timeframe from the receipt of the date of the request for the study or from completion of the study? Please clarify.

Due to the potential varying level of efforts in individual focused studies, it is recommended to TMA that the report be due following conclusion of the study. Further, it is recommended that the time frame to complete the report be based on the complexity of the individual study and negotiated with TMA as focused studies are identified, but never exceeding 90 days after the completion of the study. For example, the initial report on a focused study of one-day stays might be very easy to complete, resulting in a final report within 30 days, while the report on utilization patterns of cardiac catheterization procedures would require risk adjustment and take a longer time for final analysis and reporting – the full 90 days. TMA may also have pressing needs for particular focused study results and this would ensure flexibility.

Response 45: (Response modified 2/19/03)

It is anticipated that the RFP, when released in spring 2003, will indicate that the focused studies report delivery date will be negotiated on a per-study basis.

Question 46: Section C-7.8 addresses the draft requirement regarding reconsiderations. Will reconsideration reviews be a separate CLIN?

It is recommended that the TMA price reconsiderations as a separate CLIN. The criteria used for a reconsideration review is more stringent than that of a randomly selected retrospective review, requiring a different level of effort, on average by case.

Response 46: TMA anticipates that medical necessity appeal cases (i.e., reconsideration reviews) will be a separate CLIN in the RFP when it is released.

Question 47: In reference to C-7.10.1, initial RTC rates are determined by the current contractor utilizing data provided by the facility from 1987 to 1988. Please consider updating this rate calculation policy in accordance with other TMA rate calculations, which will allow facilities to submit reimbursement information from the current year. This data could then be deflated back to 1987, and brought forward again using the Medicare inflation factor.

Response 47: The commenter’s suggestion has been referred to the TMA office Medical Benefits and Reimbursement Systems for consideration.

Question 48: In reference to C-7.10.4, the NQMC draft requirements call for on-site surveys of mental health facilities. It also states that these on-site surveys are focused on objectives established by the COR for the particular facility. It does not state the “typical” or “minimum” level of effort required to perform these surveys. Would the TMA consider a per day CLIN for on-site survey work with a minimum of three surveyors per facility per day versus a per survey CLIN? This will allow both TMA and the contractor some flexibility in setting the requirements

for an individual survey, while providing some standardized costing direction for the potential bidders on the final RFP.

In addition, the current contractor may not bill for termination proposals that result from an on-site survey or a recertification application. If the TMA agrees to a per day of survey CLIN, will TMA agree to reimburse the contractor for the level of effort, regardless of the outcome of the survey?

Response 48: Section I of the current contract specifies two conditions when a certification billing may occur: (1) an initial determination is issued on a new facility application, a recertification application, or change of ownership, or, (2) a draft notice of termination is issued to TMA. TMA anticipates that this requirement will remain unchanged in the RFP when it is released.

The draft Requirements list specifies that three professional staff will typically be on-site for two to three days. The costs associated with termination proposals that result from an on-site survey or a recertification application should be included in the price per survey in Section B of the offeror's proposal. TMA does not anticipate changing the survey requirement to a per-day CLIN.

Question 49: The current contractor is required to ensure that certified facilities perform annual evaluations of their compliance with TRICARE standards, which currently is not reimbursable. Will the final RFP expand on the contract functions to include this responsibility as a CLIN?

Response 49: There are two CLINs associated with facility certifications: one for facility certifications, and another for on-site visits. Although there is not a separate CLIN for performing annual evaluations associated with facility certification, TMA anticipates that the costs associated with this effort will be included in the appropriate existing facility certification CLIN. TMA anticipates that this requirement will remain unchanged in the RFP when it is released.

Question 50: Peer reviews currently are reimbursed per case versus per number of peer reviewers requested to complete the review. When the issue is a provider audit or provider sanction, the reviewer must examine the records of multiple patients. It is recommended that TMA reimburse for these reviews in the same way that malpractice reviews are priced, i.e. per review requested and per patient record.

Response 50: TMA anticipates that the RFP, when released, will reflect that peer reviews will be reimbursed similarly to malpractice reviews (i.e., per review requested and per patient record).

Question 51: During the December 2002 Industry Forum, three levels of external peer reviews were proposed, each with a different time frame for completion, based on a designation as urgent, routine, or extended peer review. Please consider a tiered level of pricing for the routine and extended peer reviews that corresponds to the number of questions a peer reviewer is required to answer (i.e. less than or equal to 20 questions, greater than 20 questions).

Response 51: It is anticipated that the RFP will reflect two levels of external peer review (urgent and routine), but that pricing will remain on a per review basis and will not be changed to a per question basis.

Question 52: Section C-7.1.5 states that, "Any offeror that has a contract or agreement with a TRICARE MCSC or Designated Provider (DP) is not eligible for award."

(a) Is a contractor having a contract or agreement with a MTF, including the National Quality Monitoring Program (NQMP) contractor, eligible to pursue this award?

(b) Is a contractor who is presently a subcontractor to a Managed Care Support Contractor (MCSC) eligible to pursue this award if they will no longer be a subcontractor to the MCSC under T-NEX?

Response 52: (Response modified 2/6/03)

(a) An offeror having a contract or agreement with a MTF, including the NQMP contractor would be eligible to pursue this award. In the hypothetical situation suggested in (a), the agreement or contract is with TMA for the NQMP (or the MTF), not with a Managed Care Support Contractor or Designated Provider. The offeror would not be viewed as a competitor to one of the MCSCs or DPs, and is not working for the entity it would be responsible for monitoring as the NQMC.

(b) The arrangement suggested in (b) would not be acceptable to TMA. The question implies that a potential offeror at the time that offers are submitted and evaluated would also be a subcontractor to a current TRICARE Managed Care Support Contractor. An offeror cannot have an agreement or a contract with an MCSC or DP at the time the proposal is submitted, as that is the only way TMA can absolutely ensure that the NQMC can provide independent and objective reviews without any conflicts, perceived or real.

Question 53: The current contractor is responsible for processing incident reports and program changes such as key personnel changes, program additions, location changes, capacity changes, withdrawal of certified facilities, facility terminations and suspension of program services that are not reimbursable (Sections C-7.10 through C-7.10.4 of the draft requirements). Will the final RFP expand on the contract functions to include these responsibilities as CLINs?

Response 53: It is anticipated that the RFP will not reflect these responsibilities as CLINs.

Question 54: In the Q & As, Question 7 asked what the value of the current contract for the oversight of the seven regional MCS contracts. The response stated that upon award, the value of the fixed-price contract was estimated at \$13.4 over five years. Would TMA please provide the total of the payments made for the current contract for the 5th year, November 1, 2001 to October 31, 2002?

Response 54: Based upon invoiced submitted through December 2002 for Option Period 5 work, TMA has paid the current contractor approximately \$3.3M. Although the majority of the current contractor's effort has been vouchered, there is still additional work to be invoiced, so this

amount will undoubtedly increase, but TMA cannot estimate the amount of outstanding vouchers.